Texas Department of Health Retention Schedule for Medical Records (Guidelines for Doctors' offices and Clinics) *

Record Type	Minimum Retention Period (Based upon age as last date of service.)	Footnotes
I. **Program Medical Records** Adult Health Child Health Chronically Ill & Disabled Children Family Health (footnote1) Family Planning (footnote 2) Maternal Health (footnote 3) Sexually Transmitted Diseases (footnote 4) HIV/AIDS (footnote 5) Tuberculosis (footnote 6) Communicable Diseases Dental Records Dental Referrals	7 years past the last date on which service was given or until the patient's 21st birthday, whichever occurs later. (22 TAC 165: http://info.sos.state.tx.us/pub/plsql/readtac$ext.ViewTAC?tac_view=4&ti=22&pt=9&ch=165&rl=Y)	(1) If records of several family members are located in same file, recommendation is based upon age of youngest family member. (2) (a) Title XX records should be kept 7 years past the date of services or until the 21st birthday, whichever occurs later. (b) The retention period of records that show use of an I.U.D. will begin to run at the end of the effective life of the I.U.D. (c) The retention period of records that show the surgical implantation of contraceptives will begin to run when the contraceptive is exhausted. (3) All maternal health records must be retained for 7 years past the last date of service or until the infant's 21st birthday, whichever occurs later. (4) Sexually transmitted disease medical records must be kept 7 years past the last date of service or until the patient's 21st birthday, whichever comes later. All **sexually transmitted disease intervention records**, including investigations, interviews, and disease intervention case management notes must be kept 3 years past the last date of service or until the patient's 21st birthday, whichever comes later. (5) (a) Prevention counseling notes, risk reduction plans, and case management records compiled on **HIV-positive adult clients** must be maintained for 7 years past the last date of service or patient's death, if known. For **HIV-positive children**, the records must be kept for 3 years after the 21st birthday, even in death, or 7 years, whichever comes later. (b) **CD4 online management patient information system** (Compis) reports generated from the database must be kept as long as they are administratively valuable. CD4 online management patient information system (Compis) database records are kept for 3 years past the end of the Ryan White Title II contract period. (c) **HIV/AIDS disease intervention records**, including investigations, interviews, and disease intervention case management notes must be kept 3 years past the last date of service or until the patient's 21st birthday, whichever comes later. (d) **HIV-positive anonymous test results** (includes serology, counseling notes, risk reduction plan, and prevention case management notes must be maintained 1 year past the test date or last date of service, whichever comes later. **HIV-negative anonymous test results** including serology, counseling notes, and risk reduction plan are retained for 90 days after test date, or, the results are given to the client, whichever comes first. (e) **HIV-positive confidential test results** including serology and medical records must be maintained for 7 years after the patient's death, if known, or 18 years from the last date of service. **HIV-negative confidential test results**, including serology, counseling notes, and risk reduction plan are maintained 7 years past the last date of service or until the patient's 21st birthday, whichever comes later. (6) X-rays showing significant abnormalities may be given to the patient and/or another authorized person. Unclaimed x-rays will be returned to program managers for disposition. (7) Records are of research significance and must be maintained permanently. (8) When using the C-100 Form, it is not necessary to retain the Vaccine Information Materials. (9) Screenings are mandated to take place every other year from preschool through 9th grade.
Hansen's Disease (footnote 7)	Permanent retention period	
II. **Immunization Records & Forms** (8)	Adults: 10 years following end of calendar year in which the form was signed. Minors: 21st birthday or 10 years following end of calendar year in which form was signed, whichever occurs later.	
III. **Screening Procedures** Health Risk Appraisals Blood Pressure Screening Blood Pressure Referral HIV (footnote 5) Diabetics Screening Other Laboratory Screenings & Tests	7 years past the last date on which service was given or until the patient's 21st birthday, whichever occurs later. (22 TAC 165: http://info.sos.state.tx.us/pub/plsql/readtac$ext.ViewTAC?tac_view=4&ti=22&pt=9&ch=165&rl=Y)	
Vision, & Hearing (footnote 9)	7 years past the last date on which service was given or until the patient's 21st birthday, whichever occurs later (25 TAC 37.23) (http://info.sos.state.tx.us/pub/plsql/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=37&rl=23)	
Infant Screening for Genetic or Metabolic Disorders	Until the patient's 21st birthday.	

*For records retention of medical records for hospitals see the **Health and Safety Code** Title 4, Subtitle B, Chapter 241, Subchapter A, §241.103 (internet: http://www.capitol.state.tx.us/statutes/he/he0024100toc.html)

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Record Type	Minimum Retention Period (Based upon age as last date of service.)	Footnotes
IV. **Other** Short Term Records & Master Index Records	Retain as medical records, following guidelines for the specific program with which the record is associated.	(10) Original vaccine-preventable disease surveillance forms for the following diseases: measles, mumps, rubella, congenital rubella syndrome, tetanus, pertussis, and hepatitis B, should be sent to the Bureau of Immunization and Pharmacy Support. Disease surveillance forms for other reportable infectious diseases including tuberculosis, hepatitis A, hepatitis C, Rocky Mountain Spotted Fever, Lyme Disease should be sent to the Bureau of Communicable Disease Control. (11) Financial records and documents must be retained for a minimum of 3 years following the date of the final expenditure report for the period to which the reports pertain, with the following qualifications: (a) Records must be retained beyond the 3-year period if audit findings have not been resolved. (b) Records for nonexpendable property must be retained for 3 years after its final disposition. (c) If lab screening is done in connection with specific program, e.g., family planning, maternity, etc., data on lab report must be kept with the program record and retained until the record is destroyed. (12) Remittance and Status Reports and claims to fully document services and supplies provided to a Medicaid client must be made available promptly upon request from the Texas Department of Health, Texas Attorney General's Medicaid Fraud Control Unit, NHIC, Department of Protective and Regulatory Services, and Representatives of the Department of Health and Human Services.
Communicable Disease Surveillance Forms completed by TDH personnel (footnote 10)	7 years past last date encounter occurred or until patient's 21st birthday, whichever occurs later.	
Special Projects, Research, Etc.	10 years or as designated at the time the project is implemented.	
Women, Infants, Children (WIC) (footnote 11)	3 years following the date of the submission of the final expenditures report for the period to which the report pertains (footnote 8)	
Financial Records relating to program services (footnote 12)	Minimum of 5 years from date of service or until all audit questions, appeal hearings, investigations, or court cases are resolved. [as recorded in TSL Local Schedule HR: "by regulation – *Medicare Hospital Manual*, HIM-10, Sec. 413 (B) –Rev. No. 572]"	

PAPER RECORDS MUST BE DESTROYED BY SHREDDING.
MICROFILM RECORDS MUST BE DESTROYED BY PULVERIZATION.
CONFIDENTIALITY MUST BE MAINTAINED EVEN IF OUTSIDE CONTRACTORS ARE USED.

TEXAS DEPARTMENT OF HEALTH
SEPTEMBER, 2002

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(internet: http://www.capitol.state.tx.us/statutes/he/he0024100toc.html)